that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO may not exceed $3.40 per visit for Federal FY 2009 or for individuals referenced in an approved State child health plan under title XXI of the Act pursuant to § 457.70(c), $5.70 for Federal FY 2009. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 5-cent increment.

(c) Aggregate premiums and cost sharing of the family may not exceed the maximum permitted under § 447.78(a).

§ 447.76 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current premiums, enrollment fees, or similar fees.

(2) Current cost sharing charges.

(3) The aggregate limit on premiums and cost sharing or just cost sharing.

(4) Mechanisms for making payments for required premiums and charges.

(5) The consequences for an applicant or recipient who does not pay a premium or charge.

(6) A list of hospitals charging alternative cost sharing for non-emergency use of the emergency department.

(7) Either a list of preferred drugs or a method to obtain such a list upon request.

(b) The State must make the public schedule available to the following:

(1) Recipients, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, and the aggregate limits are revised.

(2) Applicants, at the time of application.

(3) All participating providers.

(4) The general public.

§ 447.78 Aggregate limits on alternative premiums and cost sharing.

(a) If a State imposes alternative premiums or cost sharing, the total aggregate amount of premiums and cost sharing under section 1916, 1916A(a), 1916A(c) or 1916A(e) of the Act for individuals with family income above 100 percent of the FPL may not exceed 5 percent of the family's income for the monthly or quarterly period, as specified by the State in the State plan.

(b) The total aggregate amount of cost sharing under sections 1916, 1916A(c), and/or 1916A(e) of the Act for individuals with family income at or below 100 percent of the FPL may not exceed 5 percent of the family's income for the monthly or quarterly period, as specified in the State plan.

(c) Family income shall be determined in a manner and for that period as specified by the State in the State plan including the use of such disregards as the State may provide.

(1) States may use gross income or any other methodology.

(2) States may use a different methodology for determining the aggregate limits than they do for determining income eligibility.

§ 447.80 Enforceability of alternative premiums and cost sharing.

(a) With respect to alternative premiums, a State may do the following:

(1) Require a group or groups of individuals to prepay.

(2) Terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(3) Waive payment of a premium in any case where it determines that requiring the payment would create an undue hardship.

(b) With respect to alternative cost sharing, a State may permit a provider, including a pharmacy to require an individual, as a condition for receiving the item or service, to pay the cost sharing charge, except as specified in paragraphs (b)(1) through (3) of this section.

(1) A provider, including a pharmacy and a hospital, may not require an individual whose family income is at or below 100 percent of the FPL to pay the cost sharing charge as a condition of receiving the service.

(2) A hospital that has determined after an appropriate medical screening pursuant to § 489.24, that an individual does not have an emergency medical condition, before imposing cost sharing